MENTAL HEALTH WORKGROUP MEETING
PREFERRED DRUG LIST
OCTOBER 22, 2004

Attendees: Chuck Hunter
Gary Mihelish, DDS
Julie Maggiolo
Bobbie Renner
Mignon Waterman
Dan Peterson

Chuck asked if there were changes to the minutes of the October 1, 2004 minutes. Julie asked for clarification on Off-Label Drug Use. Is the purpose to discuss issues regarding drugs and patient protection? If a discussion occurred the minutes should contain a notice of decision. Handouts should be noted. She asked if there is some type of updating for clinicians. Do we do mailings? Chuck and Dan said there are no mailings but information is provided in the Claim Jumper and is posted to the website. Julie went on to say there was a discussion on Lamictal at the October 1st meeting and a decision was made but was not reflected in the minutes. Dan and Julie will provide a description of the dialogue to put in the minutes. This type of drug is not on the PDL. Most states won't put in on their drug list. MHSP would require prior authorization for Lamictal, Medicaid would not. Chuck stated this is not a PDL item; should be put on a future agenda as a non-PDL discussion. Julie's concern is we are giving no PA for some medications and we need to open up for other diagnoses such as PDSD and eating disorders. She questioned the last sentence in the paragraph regarding Grandfathering Discussion and it was agreed to delete the last sentence.

Dan mentioned that CMS has requested additional information regarding Montana's State Plan Amendment that will enable Montana to enter into the National Medicaid Pooling Initiative for the purpose of collecting Medicaid supplemental rebates. CMS asked for responses to five questions. Dan is in the process of responding to the questions.

Bobbie asked if the questions and responses will be made available to the public. Dan said there is no approval on the responses yet, but after approval, the responses will be available to the workgroup members. Chuck said multi-state efforts will be approved by CMS. They are trying to ensure that there will be providers other than First Health. Chuck said the public information would include amount we saved on PDL.

The next Formulary Committee meeting will be held on October 27th at the MACO building.

We will incorporate Comprehensive Neuroscience in with the current DUR process. Work with Mark to put together a contract. This effort is similar to the Texas Neuroscience Review of claims for best practices. The information will be provided to physicians. The contract will be between CNS, Lily and DPHHS. Lily will provide payment. We will have to receive approval from CMS to enter into the contract.
Mignon asked that we further address the update to clinicians. Dan stated the way the updates are given to providers is through a Claim Jumper notice to pharmacists and mid-level practitioners that the updated information is on the Medicaid website.

Chuck introduced Geralyn Driscoll, DPHHS attorney, to discuss the grievance/appeal process. Geralyn provided a handout and briefly outlined devising a system that will achieve fair play, protect the rights of clients and comply with Medicaid requirements and state law. We currently have a two-tier review process – Department Administrative Review and a Request for Fair Hearing. Can we collapse into one hearing? A peer review – contract with individual to carry out function in area of needed expertise – pharmacist? More efficient, more timely than present process. The client needs someone to bring the request forward; they will not do it themselves. The following steps were discussed – starting with PDL list. If drug is listed as not preferred on the PDL, a prior authorization is required from the Mountain Pacific Quality Health Foundation. If prior authorization is denied the client could appeal the decision to the staff pharmacist for a more extensive review. The staff pharmacist, acting as the administrative reviewing officer would then render a decision on the appeal. If the administrative reviewing officer denies the appeal, a Request for Fair Hearing can then be filed. This must be a timely process. Currently, if a Prior Authorization denies, the DUR Board is the next step. Client can bypass the DUR review if they request a Fair Hearing.

Some questions raised:

Does the patient have access to the drug prior to final outcome at no cost to client if DUR says "No"?
Is it possible to get phone approval from staff pharmacist after the PA disapproves if hearing date is 30 days away?

Decision: DUR and pharmacist have to know all decisions. Must have right to review. Information to reviewer has to be part of record and it must be a written decision.

Bobbie stated that the DUR Board is very conscientious in their decision-making. They look objectively at the health issue.

Dan outlined the steps to be taken to determine drug availability:

Client to pharmacist
PA required
PA request called in
PA denied
Hand client hearing rights
Call Foundation and/or Pharmacist (Look at it again – set for administrative review, appeal or settle)
If denial is issued the client or the advocate can make the decision of hearing.

Gary stated that this is where the system will fail the patient. A patient with mental illness will take this as another personal failure. The provider should know if PA is required. The pharmacist should call the provider, the provider calls for PA and decides whether feasible. The rule should be written that the physician can start due process on behalf of patient.

Bonnie, Anita, Dan and Duane should meet to discuss the appeal process.

Oregon and Oklahoma have set up a process through the Kaiser Foundation that allows a 72-hour drug prescription fill until the appeals process is done.

Dan said Montana already has this process in place.

Questions were asked "Who advocates for mental health patients and Medicaid mental health patients?" "What kind of training do they receive?" "Where does the money come from?"

Suggestion made that maybe a peer or family member be trained to advocate.

Geralyn indicated there could be a different process of mental health due process. We could address advocacy but not make it a part of appeal process. It's possible to make a phone call part of record in order to shorten the process.

Chuck asked how many claims we anticipate. Believes maybe three-fourths will be resolved.

Gary stated we need information from other states to review for our problem solving. He will make phone calls for information and get it to Dan. Will bring proposal back to next meeting.

Grandfathering up to one year for provider and patient to request PA. Mignon asked if sometime after the PA is given and if a generic drug is approved, does the patient have to take the generic? That will be addressed.

Bobbi asked that the workgroup receive any handouts and/or proposals prior to the meeting.

PDL – do we shift costs; what are next steps; what agenda do we consider outside Medicaid? How do we get information? Joyce DeCunzo will have data. Consider a contract with Justice to receive arrest information; number of calls responded to, number of crisis calls.

Gary said we need information on Medicaid recipients. Should monitor the medication changes, analyze all information whether PDL or non-PDL.

Chuck asked that at the next meeting we firm up agenda; how we measure; how it correlates with Medicaid population.

Discussion on how we figure savings:

1. Saved due to change in medications to PDL
2. Amount of rebate

Will be baseline report for last month before PDL begins; future reports will show shift. It is important to show if client stayed on drug they were on and savings was on rebate instead of change to drug on PDL so savings could be reported.

Gary provided a handout on Evidence Based Practices.

Chuck asked what needs we sense for future meeting:

1. Grievance appeals
2. Measure of program

How many more meetings are necessary, what it takes to wrap up?

Decision made that two more meetings will be held and a summary report of the meetings will be done.

The grandfathering question was brought up again and we were asked to make our policy clear up front. Policy – use generic drugs first unless pre-existing condition merits name brand.

Julie asked that we be clearer on anti-psychotics.

1. Evidence based
2. Going over FDA approved dosage (prior approved okay)
3. Talk to Mark about this

Mignon stated there has to be correlation between hospital meds and everyday meds. What regimen will they be on upon discharge. Agreement that this should be part of final report.

Group decided there will be two more meetings. November meeting will be cancelled and hold the December 3rd meeting and another in early January. Need to draft the report by December meeting.

December 15th is date for public hearing.

1. Board review drugs
2. Informs states
3. Possibly to committee on 12/22

Gary wants discussion on policy for anti-depressants. List all items for discussion and put on December 3rd agenda. Nevada's list is available on website at http://Nevada.fhsc.com. Alaska's information is on their Medicaid website.

The next meeting will be Friday, December 3, 2004 from 1:00 to 4:00 pm in the Sanders Building, Room 207. Final meeting will be held at the same time and location on January 14, 2005.